Notice of Privacy Practices-

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. Please review it carefully.

1. Who we are

This notice describes the Privacy Practices of the Augusta Mental Health Institute and of all the individuals who work in this facility.

2. Our Privacy Obligations

We are required by law to maintain the privacy of health information we have about you (**Protected Health Information-PHI**), to inform you of our practices, and to follow them.

3. Disclosing and Using Information WITH your consent

When you begin receiving care from us, we will ask that you (or your legally authorized representative) sign a **Consent form** which permits us to release information about you in order to care for you, to be paid by your insurance company for the care provided to you, and to conduct our regular business activities.

This Consent permits us to share information, including psychiatric information, information pertaining to substance abuse, and information pertaining to HIV testing and treatment in the following cases:

- To providers within the Behavioral and Developmental Services Department described above in order to care for you
- To inform your insurance company that you are receiving services and attempt to receive "preauthorization" as may be required for you to receive insurance coverage for these services
- To release whatever information is deemed necessary by your insurance company, including copies of records, in order to get the bill paid,
- To evaluate the quality of the care we provide
- To resolve any complaints that you may have

4. Using your PHI with your AUTHORIZATION

As described above, we will use your signature on the Consent form to release information for treatment, payment, or health care operations. We may use PHI for other reasons only when we : 1) have a specific authorization signed by you or your legally authorized representative or 2) there is an exception as described in section 5 below. You

have the right to withdraw your permission at any time, and you may do this by sending us a letter at the address below.

5. **Using your PHI <u>without your Consent or Authorization</u>**.

We will always try to obtain your (or your legal representative's) consent or authorization when we use your PHI. However, there are some occasions where we may be unable to obtain your consent or authorization and we will still need to use your PHI. We will try to use only what is absolutely necessary to accomplish the purpose. Examples of when we might use PHI about you without consent or authorization include:

- If you require emergency treatment
- We are unable to obtain your consent or authorization, but we are required by law to treat you
- We are required to report cases of suspected abuse and neglect of children and incapacitated adults
- We are required to report certain diseases to the Public Health Authorities so that they may stop the spread of disease
- We are required to inform the authorities if we believe you represent a threat to the safety of someone in the community or to yourself,
- We are required to provide information about you to organizations which oversee the care we provide
- We may be required to provide information about you in response to an investigative subpoena or court order (including to certain law enforcement officials)

- We are required to report information about products you may have used to the Food and Drug Administration
- We are required to report information to the coroner or medical examiner if requested

- We are required to provide information to the State as needed to facilitate the process of organ donation
- We may permit access to information about you to students, contracted agencies for the Department of Behavioral & Developmental Services and others who are conducting research activities which have been approved by our Administrative Executive Committee

6. Your Rights

- If you desire further information about your Privacy Rights or our Privacy Practices, or are concerned that we have violated our practices, you may contact our Privacy Officer or Superintendent Office. You may also file a written complaint with the Program Service Director or Superintendent Office. Upon request, we will provide you with the address. We will not retaliate against you if you file a complaint of any kind.

- You will be asked on admission if you wish to be in our facility directory for the purpose of receiving phone calls, mail and/or flowers etc. We will honor your decision.
- We will accommodate to the extent that we can any request in writing that asks us to communicate with you by a different means of communication or at a different address.
- You may request access to your PHI for supervised review, or to receive a copy of your records for a reasonable charge. We will provide a copy of your discharge summary free of charge.
- You may request that we amend your records. We will comply with your written request or respond in writing why we do not feel the amendment is appropriate. You have the right in either case to add your own addendum to the records, and a copy of this addendum will be released whenever we release copies of your records.

- You may request a list of recipients of your PHI released for purposes other than treatment, payment, or operations. You are entitled to one free "accounting" per 12 month period.
- Upon request, you may receive a written copy of this notice.
- We will do our best to honor any requests you make for us to restrict the use of your information, although we cannot promise to agree to any request you make.

7. Duration of this notice

This notice goes into effect on April 14, 2003. We reserve the right to change the terms of this notice at any time. If we do, we will post the changes in the waiting areas, and you may also obtain any new notice from the Medical Records Department.

8. Medical Records Department

You may contact the Medical Records Department at:

Medical Records
Augusta Mental Health Institute
P.O. Box 724
Augusta, Maine 04330-0724
207-287-7162

We regret that we are unable to accept Email communications.

By signing, I acknowledge that I received a copy of this Notice of Privacy Practices

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Patient/Guardian Date